Narrative and Beyond

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What charm, in the strong sense of that word, which intimates a quasi-magical or medicinal effect, does storytelling have? In general, narrative forms of representation, in fiction or nonfiction, are a steady source of comfort for both author and reader (presenter and listener), though "comfort" may not be an adequate descriptive term. Homer and Virgil are not afraid to have their warriors shed tears when hearing of past adventures and tribulations, tears that satisfy deeply.

Stories about illness and loss, however, should they portray persons reduced to suffering in a passive way, at most furnish moral examples of endurance. Or, as in Richard Selzer's eloquent vignettes of painful and diseased bodies, they show how ugliness can become, through the doctor's eye and the writer's touch, a strange source of beauty.¹

Yet a conversion experience is almost needed to value a redeeming change of this kind. It is hard to believe that such consoling depictions are not a mirage. Especially since the sufferer's pain is often heightened by a specific mental anguish, a conception of fault or trespass, as in the Prometheus legend, or Dante's Inferno, or the testing of Job.

Today, for the most part, we no longer assume that mortal ills reveal the (hidden) fault of individuals, or of the human as such. We also shy away from accepting Cicero's definition of the philosopher as one who studies death (not unlike the medical doctor in this), or whose entire life, like that of Socrates, is but a preparation of how to make a good end.

Heroism, nevertheless, is not always absent from scenes of extreme suffering, though except for faction or fiction we try to confine such scenes to hospice and hospital. An implicit dramatic conflict between acceptance and defiance is often sensed, not only in the suffering person but also in the vulnerable observer.

I do not say this in order to invest suffering with an illegitimate interest. It is not the novelistic or TV potential that prompts a reflection.
of this sort but the practical task of caregiving: what is psychically necessary in order to face this ultimate labor.

Passion narratives, of course, which depict a suffering humanity, have a long religious as well as literary tradition. Prometheus, Dionysus, and Christ are gods. At present, narratives about death, illness, madness, persecution, and calamity serve as demotic and increasingly popular versions of the genre. In proliferating TV biopics, for example, they have become formulaic parts of a celebrity's journey from (often) humble beginnings, to a breakthrough to fame, then via crisis and suffering to recovery, maturity, and even greater fame.

Selzer's doctor stories are more complex. Their linkage of passion and pathology creates, as I have mentioned, a transfigurative realism, one that overrides aesthetic scruples previously limiting the serious portrayal in art of bodily deformity and its accompanying anguish. In his fictive Grand Rounds, moreover, Selzer does not present his all-too-human types as victims: in their very agony or debility, and their relations with the surgeon, they are larger than life, and even the impact of their death can have a haunting poignancy.

An early perspective on the specific affect of narratives that involve suffering, both physical and mental, is found in Aristotle's Poetics. Despite the sacred origins of Greek drama, his analysis remains entirely secular. Pity and fear, according to him, are purged or purified by the art of tragedy. His theory of catharsis continues to perplex because it posits a powerful emotional, but also satisfying response to the representation of a painful subject-matter. The formal care, therefore, with which the tragic story is told, and which Aristotle analyzes authoritatively, must have some bearing on that emotional uplift. Even when there is no possibility of a cure, or of a reversal of fortune, we would like to believe that art's cathartic effect (intense in the genre of tragedy but not restricted to it) lifts the spirits of those depressed by ills that flesh is heir to.

Empirically, though, it remains to be shown that stories, like music, can "smooth . . . the raven down / Of darkness." So far we have no poetics of narrative medicine. The claims made for this interesting new discipline are eminently practical and humane rather than overreaching. Narrative medicine is still very much a work in progress, and its having carved out a space in medical school for teaching and reflection is already an achievement.

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What is it we have learned, up to this point, about the relevance of studying literature in medical school? The following is a disorderly anatomy of the subject by an outsider, fragments or *membra disjecta* of what could go into an overview. It will be obvious that such remarks are based on my own limited roles of teacher, reader, and occasional interviewer of Holocaust witnesses.

I

As Rita Charon has emphasized, listening is not only indispensable (everybody agrees with that) but it can be, must be, developed. Influenced, like Charon, by literary studies, I have a prejudice that close reading and close listening are related. This is certainly one direction to be explored in training medical staff.

Close reading, moreover, goes with close writing: with thinking about style (in *Letters to a Young Doctor* Selzer admits he does this obsessively). We are talking here about self-presentation, certainly, yet no less about presentation of the other. A morally sensitive problem makes itself felt: How can I create a new kind of holistic chart for the patient (during the illness, or as a sustained reflection on it afterward) and not be distracted by the confessional egotisms necessary for an honest account of my experience as it becomes an I/thou encounter?

II

There is an instinctive aspect to listening. This watchfulness of the ear may come from the link between apprehending and being apprehensive. But as a creative flair it contributes to that “delight in imitation” deemed to be universal by Aristotle. A thoughtful replay of one’s own or another’s experience, however difficult the experience may have been, gives pleasure to both presenter and listener because the mimetic talent has found an aim, becoming mimicry in the service of mastery—yet also something more significant.

Indeed, I would like to emphasize that which cannot be subsumed under the notion of mastery. There is, on the one hand, the doctor’s perspective, and, on the other, the patient’s. Their typical narratives differ. It is important, as Arthur W. Frank makes clear in his remarkable *The Wounded Storyteller*, that we recognize the variety of illness narratives that exist, but also that the claim of a “sovereign consciousness” may have to be given up. Frank quotes Jean Améry, who writes
(brought to that realization by Nazi torturers), "there are situations in life where our body is our entire self and our fate." Today, however, the main tendency is for cultural and commercial influences to favor what Frank calls "restitution narratives" whose story line reinforces "the expectation that for every suffering there is a remedy."5

III

The sense that story line and lifeline are connected is more than literary palmistry. Scheherazade kept an Emperor awake; her 1,001 suspenseful tales suspend a death that had been decreed. We, as patients, have to keep the doctors awake. Not a lesser task, given present health-care conditions . . .

A hospital is full of stories, then; but they remain, most of them, doctor stories adjusted for the good of future patients and caregivers. Stories from the other side, by powerless observers, may seem useless. The vocabulary of agency predominates in our professional discourses. It is hard to draw sustenance or communicable lessons from situations like the deathbed watch depicted in Ingmar Bergman's Cries and Whispers, a morbid film that only just avoids the non plus ultra of passive despair, and so a flight (not always restrained in other Bergman films) into spiritualistic fantasy.

More bearable, somehow, is a further extreme situation (also not absent from films): when friends keep a comatose patient alive. Hope in a "resurrection" then becomes tangible through talking and touching and nonabandonment—through projecting a watchful, caring presence. The lifeline here takes the form of stories read to a seemingly unconscious person, or a refusal to let the latter's immobility and silence abort the stream of talk. Some mourners carry on that conversation even after a loved one's death.

IV

Narrative medicine encourages eliciting a history from every patient, however word shy or afflicted by elective mutism. This potential dialogue needs time to develop, and the modern hospital or consulting room has little time. So that the often inarticulate story inside the patient gets to be abbreviated rather than fully told. Still, the physician-listener must assume that something of the (call it) gestalt of the person treated can be glimpsed in the brief time allotted. This
requires not only the doctor's interpretive patience, strengthened by what Charon calls "narrative competence," but also an avoidance of acting out. (Such acting out is described by Selzer, who admits to quirky lapses under the pressure of a surgeon's "mad" vocation). The aim should be a sympathetic absorption of each person's words and demeanor, so that no one is too quickly classified, shunted into a diagnostic type, frozen into a symptomatic category.

The physician, then, despite the constraint of time, cultivates an empathy that ideally seeks to bring forth the patient's own understanding, even self-discovery. Healing, or minimally the will to be healed, begins with the hope of reaching, by means of words, the "shoreline of a heart."6

Thus what seems of paramount importance is the element of trust. The patient should feel able to rely for support on the hospital staff's "affective community."7 In that sense all medicine is family medicine.

V

The physician too needs a measure of reciprocal satisfaction. This cannot often come from the person being treated, who is still in pain, and necessarily self-absorbed. It has to come from a quality of self-awareness in the doctor, a learning curve that is more than quantitative, as in teaching, where one draws on classroom encounters previously thought about, and which now help the teacher to proceed in ways that lessen the sheer opacity or resistance of the human text.

VI

_The human text._ Is that an unfeeling metaphor for the living or dying human being? Not if we—teachers, doctors, observers—are part of the text, if we have to read also in ourselves. That figure of speech is not meant to promote a one-way, distancing objectification, a professional deformation satirized by John Donne's "Hymne to God my God, in my Sicknesse":

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Whilst my Physitians by their love are growne
Cosmographres, and I their Mapp, who lie
Flat on this bed, that by them may be showne
That this is my South-west discoverie
Per fretum febris, by these streights to die
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Donne's bravado in sickness is extraordinary. His meditations (a habitual, formal exercise, practiced by him in sickness or in health) on a medical crisis and the recovery from it are the kind of narrative that rivals exemplary modern instances in its self-conscious imaginative reach. The author "reads" the behavior of the physicians and the course of the disease, and ranges, by means of hyperbolic analogies, from the little world of man, and the close prison of the sickroom, to macrocosmic regions beyond the sun and just shy of God.⁹

VII

Two difficult issues, finally, must be broached. One is: How can empathy be taught? Culture as "kulcha" is a fallible instrument of humanization. The lover of music or literature can use that cultured sensibility to become blind to the suffering of others and even, in the very name of culture, to murder. We have experienced this massively in our time.

As we come to know more about brain physiology, we also learn what biochemicals are involved when persons are consistently unfeeling. But this does not answer the question of how, absent a chemical intervention, people can be brought to feel for other people; or, in diagnostic terms, what causes a severe emotional deficit, a callous or "beautiful" indifference.

Is such behavior linked to panic about a potential loss of status or self-identity? To speculate further: Could that panic be triggered by boundary problems, a compulsive tendency to overidentify? Short of pharmaceutical treatment, then, can there be empathy management, as we now have pain management? And what role could the arts play, in the light of our notorious ability to compartmentalize feelings? Still, one cannot rule out the contagious effect of a sensibility like Tolstoy's. His sympathetic yet unsentimental understanding of the characters he presents can be exemplified by "Master and Servant," a story in which the distance between the educated, classy master and his peasant sled driver is gradually worn down during a catastrophic snowstorm in which, finally, both attempt to save each other by sharing their body warmth.

These large questions need to be broken down into manageable bits. But even one of those bits, how to increase the sensitivity of health-care professionals—or to renew it, since it is always being worn
away—may need the refreshing detour of literature or other types of innovative experimentation, and that has started in the emerging field of the medical humanities.

The second issue concerns human experimentation, the possibility of a scientific study of such problems. Science is not pursued in a vacuum; the scientific method has its own problematic. The Milgram experiment, which is precisely about willingness to inflict pain in the name of science, had an elegant simplicity as well as a devastating lesson to impart. Since ethical questions bearing on medical decisions are now taken very seriously, and the bioethicist has become a fixture in most schools, the kind of discussion common to literary seminars should seem less extraordinary. Such a discussion has always covered silences as well as words, indirect modes of expression, the relation of all components—narrative, symbol, metaphor, point of view—to one another, as well as the emotional or ideological complexities in the characters represented. It is surely a propaedeutic boon to have the time to think freely, to explore the very process of interpretation, without having to do it in a state of emergency.

But to return to the Milgram experiment: it may harbor unexplored implications. Does it point to the well-known mechanism of identification with the aggressor? Why should such an impulse, however, outweigh a possible identification with the victim or person in pain? The issue, therefore, of how to cultivate empathy and judgment together, and whether professional literary study could help this endeavor, remains to be explored.

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Let me describe a humane experiment, an ongoing project with intriguing relevance for the medical humanities, including narrative medicine. The project, so far, has helped those who suffered a traumatic assault that violated every habitual norm, exceeded the understanding, and attempted to dismantle, in the groups targeted, their human dignity and very sense of self. I am referring to the extreme case of victims of the Holocaust.

After the war, some find a refuge in Israel. They are safe, or are they? Memories remain—traumatic memories. In Israel the unsympathetic attitude of many Sabras (or aspiring Sabras) was: You should have known to emigrate earlier, to leave a corrupt diaspora. Now get on with your life.
A survey in 1993, almost fifty years after liberation, found that a large number of elderly Holocaust survivors were chronic patients in mental hospitals. These survivors, according to the authors of a recent report, had not been treated as a specialized group, and at least their trauma-related psychopathology [may have been] to some degree not fully addressed in their chronic treatment since their arrival in Israel following their Holocaust experience. They [the researchers] document that in one of Israel’s largest mental health centers, nearly 67% of the 74 psycho-geriatric patients were Holocaust survivors (strikingly, almost all of them women) with 30% having experienced chronic hospitalization since the Holocaust. In a large number of these patients, it was reported that the medical chart contained no information of the patient’s persecution experience during the Holocaust.\textsuperscript{12}

Ten years later a group of psychiatrists finally receives permission to employ videotaped interviews in order to decide the proper care for these patients. As part of such rehabilitation, they investigate “the effects of addressing long-term post-traumatic sequelae.” The survivors are encouraged to tell their story, however belatedly. The question not fully answered, but which haunts this effort, is whether survivor patients would “experience relief to some extent had they been able or enabled to more openly share their severe persecution history.” The experiment, basically and belatedly, tries a story cure, or more precisely, a testimony cure. Testimony about the Holocaust, as well as the victim’s subsequent life, is to create a videotaped autobiography that can be studied by others in addition to being viewed by the patients themselves.

I should add a disclaimer before continuing. That I focus on this experiment does not imply in any way that Holocaust survivors have a greater need for psychiatric care than others who have experienced extreme trauma, or that the testimony archive Yale has been building up for twenty-five years was motivated by anything except giving witnesses a chance to freely tell what they had seen and heard, and what their present reflections are. Yale’s testimony archive set out to record Holocaust memories and realities by means of oral history. This effort has a value independent of any therapeutic effect, which may or may not occur. Its importance for the future will be helped by its open and unstructured character, that it did not pursue any agenda, since that might foreclose questions from succeeding generations.
The Israeli Hospital project I have described employs recognized scientific parameters; and my choosing it is a necessity, given the difficulty of finding careful humanistic experiments with implications for health care. So far the results of using a video-testimonial method on patients long neglected have been encouraging, at least for the nonpsychotic survivors. The experiment justifies thinking about the method’s relevance to more usual cases of posttraumatic stress. The participant doctors are led to the following optimistic remark that points clearly to the potential of narrative medicine:

It has been suggested that the testimonial method alleviates many chronic symptoms by transforming the painful trauma story into a cathartic experience and document which could be useful to other people. In this way some of the response which the extremes of suffering would have created in the survivor could be channeled and elaborated upon in a constructive manner. The video testimonial event is framed by its purpose, the creation of an autobiographical document that has as its centerpiece the traumatic experience. It is a collaborative venture, during which the interviewer recedes much more into the background and the patient is said to be assisted by means of the narration of personal experience into a new social context.

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I want to end by suggesting that more could be done in the medical humanities with different aspects of literature, not only its narrative component. I am sometimes uneasy with how narrative as a concept has taken over (in literary studies too). While there is no need to fuss about the habit of using “narrative” and “story” as synonyms, it should be clear that “story,” in this medical context, points to a mode of presentation that involves a distinctively engaged rather than detached or omniscient observer. That is also why “bearing witness” and “testimony”—not carrying, necessarily, a religious overtone—enter the discussion. “Narrative” remains appropriate, however, because it is a term giving weight to both the (potential) expressiveness of the person in pain and the scientific, cognitive side of the clinician’s professional work. The problem comes from such generalizations as “No moral theory can be adequate if it does not take into account the narrative
character of our experience." A striking aphorism, but on the face of it false. Yes, the narrative turn in medicine is also an ethical turn. But is experience intrinsically narrative (let alone ethical)? It may have that character retrospectively, or when planned in advance and executed according to plan. Yet experience usually involves something hidden, oblique, unresolved, something that follows a precarious and uncertain path. Hence the suspense, as well as vacillations in the reader’s empathic response.

Storytelling’s internal progress, from purpose to passion (in which bearings are lost) to perception, reveals other determinants: the intervention of chance, for example, and various nonteleologic elements. The narrative flow halts, digresses, turns this way and that, seems to lose its way—just like the protagonist. What often affects us, especially in the “passion” or crisis phase, is a mental or bodily short circuiting, a turbulence swirling around a fixed idea, and resembling love in Shelley’s definition (though love defeated): "a going out of our own nature, and an identification of ourselves with the beautiful which exists in thought, action, or person, not our own." Here is where symbol and other strong poetic figures come into play as forceful condensations. The literary shows its existential rather than conventional side and points to the link between symptom and symbolic action. The body tries to speak: the physiologic or psychic marker that challenges the physician should also shield the patient from being considered a passive medical object.

In sum, there is a thinking with stories as well as about stories. This has already produced a multitude of memoirs in our autobiographical culture. The point is not, of course, to have every serious illness end as a book.

That would be a sterile move. The call is for a thinking that encourages the physician to “follow the patient’s narrative thread,” to negotiate pathways illumined by an expanded concept of narrative poetics. It is to be sensitive also to nonnarrative, apparently consequential or lyrical moments, surprises in the narrator’s mood and mode: one learns to respect fragments of speech, abrupt figurations, shifts, jump cuts, mixed genres. It also means, while synthesizing all these features and having them accord with, or even alter, “the professional narrative voice of medicine,” to respect what does not fit. For there may be more than one story struggling to emerge, as in a multiple birth.
NOTES

1. See Selzer, Letters to a Young Doctor.
4. Jean Améry, At the Mind's Limits: Contemplations by a Survivor on Auschwitz and Its Realities, trans. Sidney Rosenfeld and Stella P. Rosenfeld (New York: Schocken, 1996), 90–1, quoted in Frank, The Wounded Storyteller, ix. On the difference between doctor and patient stories, or between those originating in very different cultures dealing with illness, death, and therapy, see also the fine chapter on "Narrative Incommensurability" in Hunter, Doctors' Stories, 123–47.
5. Frank, 25.
6. Celan, "Speech on the Occasion of Receiving the Literature Prize of the Free Hanseatic City of Bremen."
7. See Halbwachs, The Collective Memory.
8. Donne, "Hymne to God my God, in my Sickness."
9. See Donne, Devotions upon Emergent Occasions.
10. See Milgram, Obedience to Authority. This is based on experiments carried out by Milgram at Yale from 1961 through 1962. They demonstrated how ingrained obedience/submission to authority was (in this particular case, the authority of an experimenter claiming a scientific justification for inflicting physical pain) in a large majority of people tested, consisting of New Haven volunteers.
11. Milgram disqualifies the instinct of aggression argument in chapter thirteen of his book, but he does in effect describe obedience as motivated by identification with a social order that is viewed as a necessary source of authority.
12. This excerpt and the quotations that follow come from Strous et al., "Video Testimony of Long-Term Hospitalized Psychiatrically Ill Holocaust Survivors." The report has been accepted for publication in the American Journal of Psychiatry.
13. Connelly, "In the Absence of Narrative," in Stories Matter, 139. Connelly differentiates between the object of discourse (the story) and the discourse itself (narrative knowledge): "Narrative knowledge—comprehension of the specific, unique, detailed, and situated individual story." From a Saussurian perspective, the relationship of story to narrative could be viewed in the light of the "parole" "langue" distinction.
15. I am recalling categories used by Fergusson in The Idea of a Theater. Since the medical interview, or the sustained conversation to which it may lead, is a duologue, an element of the theatrical (or performative) does enter.
18. Charon and Montello, Stories Matter, ix, "Introduction."
19. Poirier, "Voice in the Medical Narrative," 57. See the entire essay in Stories Matter, 48–58. This question of professional stylization or authoritative tone has also been raised recently in the field of history, when the topic is social and political suffering.

BIBLIOGRAPHY